HB

393

FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. HB 393

Revision Date:
Title: "An Act relating to managed care for recipients of medical assistance; ...."
Sponsor: Rep. Rokeberg
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Services
COMPONENT SERIAL NO. 2077
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $0.0

POSITIONS:						
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

HB 393 charges the Department of Health and Social Services with development of managed-care or capitated health care systems for recipients of medical assistance. A project is already underway within the division to accomplish the purposes of HB 393 with completion scheduled for June of 1996. For this reason there is no cost shown on the fiscal note for the development of the managed care system.

The Division of Medical Assistance began a project in late 1995 that is expected to identify the appropriate approaches for managed care for medical assistance programs and the steps necessary for implementation. This project is to be completed by June of 1996. Division staff are being assisted by a contractor in review of program cost and utilization data to identfy those medicaid services that may be successfully administered under a managed care approach. Identification of recipient participation requirements is included in the contract. The contractor is familiar with managed care arrangements used by medical assistance programs of other states and will help division staff to identify those which appear practical for Alaska based upon historical cost and utilization data and the availability of health-related resources in Alaska.

Prepared by: D. Williams
Division: Division of Medical Assistance
Phone: 465-3355
Date: 01/17/96

Approved by Com: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1-23-96

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HOUSE COMMITTEE REPORT

Date Referred to Committee: January 8, 1996 **FURTHER REFERRALS:** **State Affairs**
Finance

Date of Committee Action: 3/26/96

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 393**

HOUSE BILL NO. 393 **MANAGED CARE PROGRAM FOR MEDICAID**

"An Act relating to managed care for recipients of medical assistance; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 393 (HES) [X] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[X] zero fiscal note(s) H+SS [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
	✓	✓		
	✓			
			✓	
		✓		
			✓	
				✓

CHAIR'S SIGNATURE _____

ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

MEMORANDUM

To: House HESS Committee Members

From: Representative Norman Rokeberg

Date: March 20, 1996

Re: CS for HB 393

A new CS has been ordered for HB 393, and I was told it may not be available for the 3 p.m. committee hearing today. I decided that the bill needed a findings section, and I've also included some language changes requested by the department. Following are the changes:

NEW FINDINGS AND PURPOSE SECTION:

The Legislature finds that

(1) the medical assistance program under Title XIX of the Social Security Act (Medicaid) has provided adequate health care for low income individuals in the state since its enactment in Alaska in 1972;

(2) Medicaid Program costs have increased an average of 13.9 percent a year over the past five years, and the number of eligible individuals has grown from 57,251 in 1991 to 86,445 in fiscal year 1995 due to the addition of services and eligible groups by Congress and the Alaska Legislature.

(3) Medicaid Program management has evolved from a fee for service payment structure to a point where, by 1995, ninety-four percent of the states include some type of managed case model in at least one geographic area of their state;

(4) Primary Care Case Management models offer an effective system of care management, similar to the existing fee for service environment, which can generate program savings, preserve quality of care, and have been successful in both urban and rural areas; and

(5) Alaska has many unique features due to the geography, weather, and wide dispersion of population centers which challenge the creation of managed care systems in the state, however, the projected downturn in state revenues require the state to seek creative solutions in providing health care coverage for low income persons at a reduced cost in the future.

AMENDMENTS TO ORIGINAL BILL:

Page 1, line 5 after "managed-care"

Delete "or capitated"

Page 1, line 7

Delete "persons" insert "individuals or entities"

Page 1, line 7 after "of"

Delete "comprehensive"

Page 1, line 7 after "recipients."

Delete "The contract" and all material on lines 8 and 9

A NEW SECTION:

The department will implement two competitive, innovative managed care pilot projects in one or more urban areas of the state which take into account the unique features of the pilot areas and include a rural element, if feasible. Affected parties of consumers and providers of health care services in the pilot areas will be involved by the department in the implementation of the managed care plan.

The department may require that a recipient of medical assistance under AS 47.07 must participate in a managed care system developed under (a) of this section in order to remain eligible for medical assistance under AS 47.07. This participation requirement may be based on geographical, financial, social, medical, and other factors that the Department of Health and Social Services determines are relevant to the development and efficient management of the managed care system.

The Department of Health and Social Services is authorized to submit any federal waivers required to implement a managed care system developed under (a) of this section.

ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

Sponsor Statement HB 393
"An act relating to managed care for recipients of medical assistance; and providing for an effective date"

The debate in Congress over Medicaid is focused on two proposals: replacing Medicaid with block grants ("MediGrants") to the states or instituting a *per capita* cap on the federal contribution to Medicaid spending. The former plan would remove the individual entitlement, which guarantees services to eligible persons; the latter would retain the individual entitlement. Both plans would offer states unprecedented flexibility in administering their programs but there will be significant reductions in federal funds.

As the costs of medical care rises, managed care is a way of ensuring a high level of care while keeping costs down. Medicaid costs have risen by more than 50 percent over the last four years, and will cost the state $336 million dollars this year.

Persons eligible for Medicaid include the Aid to Families with Dependent Children group -- AFDC adults, poor pregnant women, and generally healthy, but poor children; and the SSI-related group -- the elderly and persons who are aged, blind and disabled. The AFDC-related group represents about 71 percent of all Medicaid recipients nationwide, but accounts for only about 30 percent of all spending.

Medigrants will distribute funds to states without regard to the particular needs and circumstances in a state and literally ignores changes in enrollment. HB 393 will prepare the state for changes in Medicaid funding at the federal level. The bill ensures adequate public debate over the issue. HB 393 asks the Department of Health and Social Services to develop legislation creating a managed care program for Medicaid.

Managed care replaces current "fee for service" program with one that requires recipients to use designated doctors and other medical providers to be eligible for benefits. Recipients can use only pre-approved doctors. At recent count, 43 states have some form of managed care in their programs.

There are opportunities and risks at all levels in this changing environment. The potential benefits of a managed care system could provide improved mechanisms for cost control while providing for greater flexibility in benefit packages, and incentives for preventative services and continuity of care.

HB 393 makes sure that the program developed by the department is one that takes into account the views of the public, the medical community and the legislature. A managed care program developed by the department should be crafted with input from everyone affected by the program. The legislature should have a voice in this matter.

Furthermore, the department has already begun working on a Medicaid Managed Care Project. As recent as October 1995, an RFP was awarded to a health management company to assist the Division of Medical Assistance in a draft five-year managed care plan. HB 393 will require legislative approval of a plan, and allow the department to have the benefit of public debate surrounding this issue.

HB 393 is a timely bill. I urge your support for this legislation.

ALASKA STATE LEGISLATURE
House of Representatives

MAR 1996

COMMITTEE ASSIGNMENTS:

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Representative Norman Rokeberg

Memorandum

To: Representative Cynthia Toohey
Chair, House Health, Education and Social Services Committee

From: Representative Norman Rokeberg

Date: March 12, 1996

Re: Managed Care for the Alaska Medicaid Program

I thought you'd be interested in the attached pages taken directly from the Department of Health and Social Services FY 97 budget overview.

As this paper indicates, the department is aggressively pursuing managed care and has already awarded a contract for a review of managed care options for the Alaska Medicaid Program.

Without passage of HB 393, the public, health care providers, health care consumers and the legislature are left without a voice in the matter. The bill requires the department to introduce their managed care program in the form of legislation next year.

I believe the department will benefit from having this managed care discussion in the public forum. Again, I urge your support for HB 393.

BACKGROUND

State of Alaska Department of Health & Social Services

Fiscal Year 1997 Budget Overview

Tony Knowles,
Governor

Karen Perdue,
Commissioner

EXAMINING MANAGED CARE ALTERNATIVES

Background

In FY 94, the Legislature provided a clear message that the Division should manage medical assistance programs to slow down the rate of growth in the program. (See Legislative intent statement, Ch. 3, FSSLA 94, page 21, lines 36-38). Some actions were taken during FY 94 to assure appropriate use of services, resulting in cost avoidance/savings of about $25 million. Many cost savings actions were enhanced or initiated in the past two fiscal years to achieve both the Legislative intent and the department's goals. The Division's Annual Reports provide brief descriptions of these activities, including contracting for case reviews and services, and initiating special projects for development of case management services and managed care programs. Some of these actions are designed to show an immediate reduction in costs, while others were begun with the knowledge that cost savings will not occur until later. Some cost-saving measures which, at first, appeared to promise savings were later found to be impractical because the action would result in utilization shifts to services which cost more, would be contrary to federal law, or cost more to administer than the service cost savings gained.

Managed Care

Building on the successes of the past two years, the division awarded a contract in the fall of 1995 for a review of managed care options for the Alaska Medicaid Program. This contract will update health care delivery information formerly contained in the now defunct State Health Plan, analyze expenditure information, review other states experiences in implementing managed care arrangements, and make recommendations for managed care delivery system options likely to work in the state. Because Alaska's health care system has not developed a managed care infrastructure, the division will not be able to simply purchase services from existing managed care networks. Movement into the managed care arena will necessitate the education of health care providers and fostering the development of health care delivery networks in addition to receiving required federal waiver approvals. The contract is timely, in that its recommendations should assist the division in dealing with Congressional restructuring, and budget reductions, currently being debated in Washington.

The division is giving special consideration to implementation in FY 97 of a managed care model called Primary Care Case Management (PCCM). The PCCM project would begin in selected areas of the state. PCCM is a case management system in which a patient enrolls with primary care provider for basic medical care. The primary care provider also manages the care of the patient, authorizing certain services such as laboratory, x-ray, and emergency room care. PCCM is the managed care model usually adopted in rural areas of the country where Health Maintenance Organizations (HMOs) don't exist.

This PCCM approach using physicians and mid-level practitioners, such as advanced nurse practitioners and physician assistants as case mangers, allows states to provide appropriate access for recipients to primary care, and to reduce unnecessary Medicaid expenditures. Under PCCM, Medicaid recipients typically are required to select a physician or mid-level practitioner who will be their case manager -- providing primary care services and authorizing in advance all other medical services (except for instances of bona fide emergency). In this way the primary care case manager functions as a "gatekeeper" for recipients who may over-utilize services and/or prescriptions. As a result of the responsibility vested in the case manager, the physician or mid-level practitioner provides more individual oversight of the recipient and, thereby, assures that the total use of services is appropriate. This effort increases the quality of care for those recipients and, at the same time, reduces expenditures for duplicative or overlapping and unnecessary services.

A waiver from the federal Health Care Financing Administration is required before the state may initiate a PCCM program. To obtain a waiver for this purpose the state must complete an application for review by the federal Health Care Financing Administration. The waiver application must clearly delineate and document the characteristics of the population to be served, the geographic area to be covered, the cost-efficiency of the proposed activity. An assurance must be made that the recipient's access to care is not limited. Waivers granted for this purpose have been relatively flexible, allowing states to design a program for physician enrollment as a primary care case manager that meets the particular need identified by the state.

From The Department of Health and Social Services

DESCRIBE THE MEDICAID

MANAGED CARE PROJECT

* RFP awarded October, 1995

* Purpose: to hire a planner/facilitator with planning expertise in the development and implementation of managed health care systems and other recent changes in state Medicaid programs.

  The RFP asked the Contractor to emphasize Primary Care Case Management model of managed care because that is a model many states have successfully started with.

* Contractor: FOX Systems/Health Management Associates

* Work Group--hand out. Nancy Cornwell is now a member. Karen was appointed as the new project director and I am her assistant. There have been four meetings to date. Now meeting twice each month for the purpose of reviewing deliverables and discussion.

* Revised schedule has us meeting through June, 1996

* Scope of Work--hand out

* Goal as stated in the RFP Scope of Work--to assit DMA in the development of a draft five-year managed care plan. The draft five-year managed care policy plan will set out a strategic implementation plan for initiating practices selected by DMA for further work. Example: year one might be implementation of a PCCM pilot project in one area with only Aid to Families with Dependent Children clients enrolled and by year five Medicaid PCCM might be statewide with all clients enrolled.

5.01
Scope of Work

The Department of Health & Social Services (DHSS), Division of Medical Assistance (DMA) is soliciting proposals for hiring a planner/facilitator with planning expertise in development and implementation of managed health care systems and other recent changes in state Medicaid programs. DHSS wants assistance to facilitate consideration of various opportunities for improving the State's Medicaid program by the Medical Care Advisory Committee and a group of policy-level state officers selected to advise the Commissioner and Governor on health issues. The contractor will, in preparation for advisory meetings, draft a description of the Alaska health system. The draft will serve as a baseline technical and policy analysis of how Alaska might implement changes to its Medicaid program that have proven cost-effective in other states. A review of current managed care activities and proposed changes, especially Primary Care Case Management, will be performed by the contractor with recommendations given to the department.

As background to the discussion of recommendations posed by the contractor, the contractor will provide an overview of various managed care practices implemented in other states. The practices to be reviewed will include, but not be limited to, capitated payments; contract service arrangements; primary care case management; use of waivers (Sections 1915 (a), 1915 (b) and 1115 of The Social Security Act) and administrative management techniques such as prior authorization, lock-in programs [42 CFR 431.54(e)], and inter-agency agreements.

Staff interviews are required only as necessary to achieve the production of deliverables under this contract. The types of staff in State agencies that the contractor may need to interview to produce deliverables and gain background information are DMA policy, operations and medical review staff. Transportation incurred for DMA staff interviews, if any, are included in the contract award.

Other helpful informational material that can be provided to the contractor includes:.

- listing of hospitals receiving municipal assistance/revenue sharing;
- Medical Directory of Alaskan Physicians;
- Medicaid Management Information System (MMIS) Provider Listing (in- and out-of-state)
- occupational licensing practitioner listings;
- Survey of Primary Care Providers in Alaska;
- State Population Estimates;
- Alaska Injury Prevention Plan;
- Child Health Plan (Interim Report, Vol. 1,2,&3);
- Alaska Adolescents: A Plan for the Future, 1994, 1995;
- 1991 Alaska Hospital Survey (and updates from Planning);
- 1994 Village Health Clinic Survey;
- Health Care Financing Administration (HCFA) listing of designated Federally Qualified Health Centers;
- Final Report - Health Resources and Access Task Force;
- Invest in Our Children, 1994 Vol. I, II, & III;
- Alaska EMS Goals;
- Certificate of Need Activity Log;
- Office on Aging Plans for Assisted Living Facilities;
- Healthy Alaskans 2000;
- DHSS FY 95 Operating Grants;

- State Health Plan for Alaska; and
- Alaska Medicaid Program Case Management, Program Background: Accomplishments for FY 95 and Activities in Progress for Later Years.

The goal of this project is to assist DMA in the development of a draft five-year managed care plan. The draft five-year managed care policy plan will set out a strategic implementation plan for initiating practices selected by DMA for further work.

NCSL STATE LEGISLATIVE REPORT

July 1995
Vol. 20, No. 7

Medicaid Research and Demonstration Programs

By
Laura Tobler
Research Analyst

A quiet revolution has taken place in state Medicaid programs in the past few years. The states, facing escalating costs and increased numbers of uninsured, have been in the forefront of health reform. Thirteen states currently have federal approval to implement comprehensive Medicaid reforms and many other states have obtained approval for smaller sub-state projects.

State officials designed and restructured Medicaid programs with 1115 waiver demonstration projects. The 1115 waiver to the Social Security Act provides the secretary of the Department of Health and Human Services broad discretion to waive certain laws pertaining to federal requirements. For example, demonstration programs may expand eligibility, require enrollment in managed care organizations and require cost-sharing. This provides the state with the opportunity to pursue Medicaid projects which test new and innovative ideas relating to benefits and services, eligibility requirements and processes, program payment and service delivery.

The 1115 waiver to the Social Security Act provides states with broad discretion to waive certain laws that pertain to federal requirements.

Waivers have succeeded in enrolling 500,000 previously ineligible people in Medicaid managed care plans. Managed care is a large part of 1115 waiver programs and is frequently used to improve access to health care, ensure its quality and contain health care costs. Although managed care is a popular delivery system in these programs, no state has attempted to enroll all its Medicaid beneficiaries in managed care for all services.

Most existing managed care organizations have had little experience serving special population clients, such as people with disabilities or mental illness and individuals requiring long-term care. Ten of the approved 1115 waiver programs plan to enroll people with disabilities in managed care and eight propose delivery of mental health benefits. Arizona is the only state that is currently providing long-term care services, although Hawaii, Rhode Island and South Carolina included it in their approved proposals. The success of waiver programs will depend

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on the ability of managed care organizations to provide adequate savings, access and quality to serve the poor, elderly and disabled Medicaid populations.

Possible Medicaid block grants could affect approved and pending waiver projects.

The future of 1115 demonstration projects is uncertain. The political composition of Congress and the possibility of Medicaid block grants will certainly affect the future of approved and pending waiver projects but the extent is yet to be determined. Ohio has federal approval for its waiver program but is now reconsidering its plan to restructure Medicaid in anticipation of federal reform. The states that have implemented and proposed fundamental changes in their programs may find that the future is more predictable if they are given control with block grants.

A chart summarizing the major features of state Medicaid research and demonstration programs follows.

Acknowledgments

The National Conference of State Legislatures gratefully acknowledges the support of the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services, and the Foundation for State Legislatures, which provided funding for this project.

1115 MEDICAID COMPREHENSIVE AND SUB-STATE WAIVER DEMONSTRATION PROJECTS
(Approved and Proposed)

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
ARIZONA *AHCCCS* Approval 1982 Implementation - 1983 Three year extension granted 4/94	Statewide mandatory managed care enrollment in fully capitated HMOs	AFDC, SSI
CALIFORNIA PACE *On Lok Senior Health Services* 7/83 *Centers for Elders Independence* 4/95 *Sutter Senior Care* 5/94	All inclusive care for frail elderly with capitation financing.	Age 55 certified for nursing home placement and residing in a defined geographical location. There are programs in San Francisco, Oakland and Sacramento. The site in San Francisco is the long term care model for the national PACE program.
COLORADO PACE *Total Long Term Care* 10/91	All inclusive care for the frail elderly with capitation financing.	65 and at risk of institutionalization. Program serves 205 clients in the city of Denver.
DELAWARE *Diamond State Health Plan* Approval - 5/95 Implementation - 1/96 *Nemours Children's Program* Approved - 7/93 Implementation - 3/9494	Fully and partially capitated managed care program. Creation of a managed care delivery system that emphasizes primary care. The state proposes including mental health and substance abuse services under the benefits packages. The state will contract with a single private agency for administrative services. A public/private manage care system which enrolls, on a capitated basis, Medicaid-eligible children in pediatric clinics. The Nemours Foundation developed the clinics and is subsidizing a portion of the service cost.	About 80 percent of Medicaid recipients will be initially enrolled in managed care plans. Expands Delaware's existing Medicaid program to provide comprehensive health coverage to poor adults and children with incomes up to 100 percent of the poverty level. Medicaid-eligible children up to 18 and not presently participating in managed care.
DISTRICT OF COLUMBIA *Health Services for Children with Special Needs* Approval: pending	The proposal seeks to provide a full continuum of high quality cost-effective services, to improve access and delivery of care, and to promote community health education activities. The district will contract with Health Services for Children with Special Needs, Inc. a local nonprofit managed care company, to administer the program using a monthly capitation rate per enrollee.	Medicaid eligible infants, children and youths up to the age of 22 who have disabilities or complex medical needs and are enrolled in the SSI program.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
FLORIDA ***Florida Health Security Program*** Approval - 9/94 Implementation - Failed to pass enabling state legislation	A voluntary, employer-based, discounted premium program designed to provide access to private health insurance for employed, but uninsured, Floridians. The program will use a managed competition model. All Medicaid beneficiaries will be required to enroll in a managed care plan. They will be given a choice of two plan types: a risk-based capitated HMO or a primary care case management program that utilizes a fee-for-service reimbursement system.	Expands coverage to individuals not covered by traditional Medicaid benefits. Mandates enrollment in provider health networks for individuals who are eligible for traditional Medicaid coverage. An estimated 1.1 million uninsured Floridians with gross incomes at or below 250% of the FPL.
Resource Mothers Project Approved - 5/94 Implemented - 8/94	Objective of the demonstration is to significantly reduce the incidence of low birth weight infants. Resource mothers will guide high-risk clients, during home visits, over a two year period.	High risk clients.
GEORGIA ***Georgia Children's Benefit Plan*** Approval - pending	Provides a package of preventive and primary care services for certain uninsured children that includes well-child visits; immunizations; acute episodic sick care in physician offices and clinics; diagnostic tests; prescription drug coverage; limited outpatient surgery; anesthesia; and emergency room care.	All children 1 to 5 who are not currently eligible for the Medicaid program and who live in families whose income does not exceed 185% of the FPL.
HAWAII ***Health QUEST*** Approval - 7/93 Implementation - 8/94	Statewide demonstration project that creates a public purchasing pool with a copayment scale for health care through capitated managed care plans. The program provides seamless coverage to those previously covered through federal and state programs and those who are uninsured by building on the state's unique exemption to ERISA.	Expansion of the Medicaid income eligibility level to 300% of the FPL and elimination of categorical requirements and asset tests.
ILLINOIS ***Mediplan Plus*** Approval - pending	A managed care delivery system using a series of networks, either local or statewide, to tailor its Medicaid delivery system to the needs of local urban neighborhoods or large rural areas.	Hospitals would arrange for a primary care physician (PCP) for Medicaid recipients. If recipients do not choose a PCP, they will be assigned an HMO. There would be a 12-month lock-in for recipients.
KANSAS ***Community Care of Kansas*** Approval - pending	Implementation of a managed cooperation demonstration project in four predominantly rural communities. Assess the success of a non-competitive managed care model in rural areas.	Expands eligibility for children under 5 Modifies traditional financial eligibility criteria.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
KENTUCKY ***Kentucky Medicaid Access and Cost Containment Demonstration Project*** Approval - 12/93 Implementation pending enabling state legislation	All those eligible will be enrolled in managed care plans similar to the state's current primary care case management program (KenPAC), or alternative managed care plans. The benefit package is the same as Kentucky's current Medicaid benefit package.	Expand Medicaid eligibility to 100 percent of the FPL regardless of categorical eligibility or assets.
LOUISIANA ***Louisiana Health Access*** Approval - denied 6/95	Proposes to implement a fully capitated statewide managed care program. Convert state charity hospital system into public HMO and use the profits to generate federal matching funds. Charged HMOs a fee to draw matching funds from federal government managed care plans.	Expand Medicaid eligibility to people with incomes up to 250 percent of the FPL; those with incomes above 133 percent would pay all or a portion of the premiums.
MARYLAND ***"Maryland Medicaid High Cost User Initiative"*** Approval - pending	Integrated case management system.	High cost, high risk Medicaid recipients under 65.
Kids Count Approved - 8/93 Implemented - 10/93	Primary and preventive care.	Expands Medicaid eligibility provided to children born after September 30, 1983 with family incomes below 185 percent of the FPL.
Family Planning and Reproductive Services Approved - 1/95 Implemented - 2/95	Family planning and preventive reproductive services.	Extend Medicaid eligibility for a five year period to women who are Medicaid eligible due to their pregnancy and remain Medicaid eligible 60 days postpartum.
MASSACHUSETTS ***MassHealth*** Approval - 4/95 Implementation pending enabling state legislation	MassHealth builds on three existing state health programs: Medicaid Managed Care, CommonHealth Program and the Medical Security Plan. The Medicaid Managed Care program provides covered services through HMOs or the Primary Care Clinician Program and will be incorporated into the MassHealth demonstration program. It also establishes two new programs, the Insurance Reimbursement Program and the New State Benefit Plan, which incorporate and expand on the programs mentioned above.	Expands coverage to individuals ineligible for traditional Medicaid coverage. Modifies financial eligibility criteria for demonstration participants. Allows families and individuals to open tax-free medical savings accounts.
PACE ***Elders Service Plan*** 6/90	All inclusive care for the frail elderly with capitation financing. Massachusetts is working on developing six additional sites.	Select frail elderly and dual eligibles in specific geographic areas.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
MICHIGAN Approval - pending Slated to begin as soon as approved	Family planning services provided through Title 10 clinics. Proposal also includes the addition of home visits, outreach services to identify eligibility, and reinforced support for utilization of services.	All women of childbearing age living in families with incomes at or below 185 percent of the federal poverty level.
MINNESOTA ***MinnesotaCare*** Approval - 4/95 Implementation - 1/96 (but may be changed by 1995 legislation, SF 845) ***Minnesota Long Term Care Options Project*** Approval - 4/95	MinnesotaCare would integrate the state's low-income and uninsured health programs and expand the managed care delivery system. Participants must enroll in managed care organizations that contract with the state to provide standard benefit packages. Premiums, copays and deductibles are required for those with incomes above the FPL. SF 845 repeals the move to full community rating and the individual mandate proposed in the original MinnesotaCare. Program combines Medicaid and Medicare funding and service delivery. These beneficiaries will be offered a comprehensive benefit package which will include coverage for portions of long term care and acute care services.	Expands eligibility for medical assistance to all families with children and incomes below 275 percent of FPL. Single adults and couples without children must be below 135 percent of FPL and must have been uninsured for past 12 months. Cost sharing is required for those with incomes above the FPL. Dual eligible beneficiaries over 65 in the seven-county Minneapolis/St. Paul metro area.
MISSOURI Approval - pending Projected implementation - 1/96	Requires Medicaid beneficiaries to enroll in managed care delivery systems. As part of the program, Missouri would create a voluntary capitated managed care pilot program to serve noninstitutionalized persons with permanent disabilities.	Individuals with incomes below 200 percent of the FPL. The uninsured in the state will be eligible on a copayment basis.
NEW HAMPSHIRE ***The Granite State Partnership for Access and Affordability*** Approval - pending	New Hampshire is completely redesigning its 1115 waiver request.	
NEW MEXICO ***Family Planning*** Approval - pending	Family planning services.	Medicaid-eligible women of childbearing age with incomes at or below 185 percent of the FPL.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
NEW YORK *Partnership Plan* Approval - pending PACE *Comprehensive Care Management* 2/92 *Independent Living for Seniors* 4/92	Fully and partially capitated mandatory managed care for all non-disabled recipients. All inclusive care for the frail elderly with capitation financing.	Guarantees eligibility to home relief population (NY public assistance program). Select dual eligible frail elderly in Rochester and the Bronx.
OHIO *OhioCare* Approved - 1/95 Implementation - put on hold by the governor	Basic benefit plan includes all the services currently covered by the state's Medicaid program. Participants will receive services through fully capitated managed care plans that will contract with the state on a county-by-county basis. It will also test use of managed care for mental health and substance abuse treatment.	All those with incomes below 100 percent of FPL.
OKLAHOMA *SoonerCare* Approval - pending	Program emphasis is on access problems in rural areas. Program encourages the development of rural-based managed care initiatives. The state hopes to employ traditional fully capitated managed care delivery models for urban areas and will introduce a series of partial capitation models in rural areas. Savings from managed care will be used to finance the development of rural health services.	All currently eligible, noninstitutionalized Medicaid beneficiaries will be enrolled during the first two years of the project. Does not expand eligibility as a part of it's program.
OREGON *Oregon Medicaid Reform Demonstration* Approval - 1993 Implementation -2/94	Fully and partially capitated HMOs. Benefits package changed to coverage based on prioritized diagnosis and treatment. The package covers virtually all current Medicaid mandates including all preventive and screening services. It also covers dental services, hospice care, prescription drugs, most transplants and therapist. Mandates managed care enrollment.	Expands coverage to individuals ineligible for traditional Medicaid coverage. Includes those with incomes at or below the federal poverty line: Women can become eligible prior to becoming pregnant. Modifies financial eligibility criteria for demonstration eligible individuals.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
RHODE ISLAND ***Rite Care*** Approved-11/93 Implementation-8/94	Mandates enrollment in prepaid health plans under contract with the state to provide comprehensive health services to participants at a fixed cost per enrollee per month. The plans will be responsible for ensuring that each participant has a primary care provider and is afforded access to all medically necessary services included in the benefit package. Modifies financial eligibility criteria.	AFDC, pregnant women and children under 6 with family incomes below 250 percent. Pregnant women enrolled in the program, who lose eligibility 60 days postpartum, will be offered the opportunity to enroll in an extended family planning program for two years.
Choices Approval - pending	The state seeks to test a capitated managed care model for acute and long term care services for program eligibles. Proposes to consolidate all current state and federal funding for adults with developmental disabilities under one program.	Developmentally disabled individuals eligible for Medicaid.
SOUTH CAROLINA ***Palmetto Health Initiative*** Approval - 5/95 Implementation - Suspended by the state	Program officials have decided to slow pursuit of the states' proposed demonstration project, citing significant changes in the state's health care industry. They now will seek to enroll only current clients in managed care plans on a voluntary basis. The original proposal was based on a partial capitation approach. It would allow primary care providers to participate without being fully at risk and without meeting financial risk reserve requirements that would be imposed on a fully capitated program.	Current Medicaid eligible individuals. The original proposal covered current Medicaid eligible individuals, individuals with incomes below 100 percent of FPL and children up to age 18 in families with incomes up to 133 percent of FPL.
Family Planning Project Approved - 12/93 Implemented - 8/94	Family planning services for postpartum women (22 months after delivery).	Extends Medicaid eligibility to all women with incomes below 185 percent of the FPL who have had one or more Medicaid reimbursed pregnancies.
TENNESSEE ***TennCare*** Approval - 11/93 Implementation - 1/94	TennCare is a statewide capitated managed care program. All enrollees are served by HMOs or PPOs. TennCare requires cost-sharing, based on income, in the form of premiums, deductibles and copayments.	Medicaid beneficiaries, uninsured state residents (this has been limited because the state has met its cap), and those whose medical conditions make them uninsurable.
TEXAS PACE ***Blenvivir Senior Health Services*** 2/92	All inclusive care for the frail elderly with capitation financing.	Select frail elderly and dual eligibles in a specific geographic location.

STATE	PROGRAM DESCRIPTION	ELIGIBILITY/ENROLLMENT
VERMONT *Vermont Health Access Plan* Approval - 8/95 Implementation - 1/96	Vermont proposes to integrate Medicaid recipients into managed care plans and to provide pharmacy coverage to low-income Medicare beneficiaries.	Medicaid recipients and uninsured individuals up to 150 percent of the FPL.
WISCONSIN PACE *Comprehensive Care for the Elderly* 11/90	All inclusive care for the frail elderly with capitation financing	Selected frail elderly and dual eligibles in a specific geographic location.

1115 Waiver - Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad discretion to waive certain laws pertaining to Medicaid, in order to conduct experimental, pilot or demonstration projects which test new and innovative ideas.

Comprehensive 1115 waiver - health reform demonstration that affecting large populations in the state.

Sub-state 1115 waiver - demonstration that affects smaller components of state Medicaid programs.

AFDC - Aid to Families with Dependent Children

Dual eligibles - individuals eligible for Medicare and Medicaid

Capitation - A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount over a specific period of time for each person served, regardless of the actual number or nature of services provided to each person.

FPL - federal poverty level

HMO - health maintenance organization

SSI - Supplemental Security Income

ERISA - Employment Retirement Income Security Act

PACE - Program of All-Inclusive Care for the Elderly. All PACE programs focus on the frail elderly; have a philosophy of care that emphasizes maximum independence and dignity; provide comprehensive acute and long-term care services package; have a multidisciplinary approach to care planning and service delivery; are based on capitation financing with the provider assuming risk.. Each center must obtain an 1115 waiver for Medicaid and a 222 waiver for Medicare.

State Legislative Reports

"Supporting Families" (Vol. 19, No. 13) (ISBN 1-55516-378-5)	August 1994
"Beyond Superfund: Voluntary Industrial Cleanup" (Vol. 19, No. 14) (ISBN 1-55516-382-3)	September 1994
"Lender and Successor Liability for Hazardous Waste Cleanup" (Vol. 19, No. 15) (ISBN 1-55516-383-1)	September 1994
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"Crime and Corrections: Crafting Policy Amid Fear" (Vol. 20, No. 6) (ISBN 1-55516-393-9)	June 1995
"Medicaid Research and Demonstration Programs" (Vol. 20, No. 7) (ISBN 1-55516-344-0)	July 1995

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National Conference of State Legislatures

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The Anchorage Times

Publisher: BILL J. ALLEN
"Believing in Alaskans, putting Alaska first"
Editors: DENNIS FRADLEY, PAUL JENKINS, WILLIAM J. TOBIN
The Anchorage Times Commentary in this segment of the *Anchorage Daily News* does not represent the views of the *Daily News*. It is written and published under an agreement with former owners of *The Times*, in the interests of preserving a diversity of viewpoints in the community.

Billions and billions

IN THE NEW Year — an election year, it needs to be pointed out again — the Medicare-Medicaid rhetoric will escalate to epic proportions.

On the one hand, President Bill Clinton's re-election forces will be posing as defenders of the two health care programs while accusing the opposing Republican camp of attempting to harm the elderly and the poor who use the government-sponsored aid.

To help keep the picture in focus, here are the numbers the politicians should keep in mind:

- Just 15 years ago, in 1980, Medicare expenditures were $34 billion. In 1994, they were $160 billion, reflecting an annual growth rate of 11.7 percent. With 36 million Medicare recipients, expenses for 1995 are expected to top $176 billion. The Congressional Budget Office forecasts the number will rise to $286 billion by the year 2000 — an annual growth rate of 10 percent over the next four years.
- Medicaid enrollment for 1995 was 36.6 billion. By the year 2000, Medicaid coverage is expected to extend to 43 million people. Meanwhile, Medicaid expenditures have risen from $41 billion in 1984 to $138 billion for 1994. The Congressional Budget Office, looking at $157 billion in Medicaid expenditures for 1995, projects the cost will be $262 billion by 2000.

That adds up to an annual cost of more than half a trillion dollars just four years from now, absent some restraints. No wonder the rhetoric is heated.

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SENIOR VOICE

ISSN 0741 2894

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Choir sings in honor of King

Senior Voice/Walter H. Panych

Verneda Freeman (left) and Faye Bradshaw (right) performed in the Rainbow Mass Choir at the Martin Luther King Jr. Holiday Celebration at the Shiloh Missionary Baptist Church in Anchorage. The multi-racial, multi-denominational choir performed four days last month commemorating King's life and accomplishments.

Medicaid eyed for overhauling

by David Washburn
Senior Voice staff

A new bill in the House of Representatives calls for an overhaul of the state's Medicaid program in order to cut costs, but could mean less health care flexibility for future low-income Alaskans.

HB 393 directs the state Department of Health and Social Services to create a plan that would replace the current Medicaid program with a managed-care system. Such a system would require recipients to use designated doctors and other medical providers in order to qualify for benefits.

The bill's sponsor, Norm Rokeberg (R-Anchorage) says a managed-care system will help control Medicaid costs, which rose by over 50 percent in the last four years. "In this fiscal year the state will spend $336 million dollars on Medicaid, which is the second largest cost component [in the budget] next to education," Rokeberg says.

Medicaid is now a "fee for service" program. Recipients choose their doctors, who in turn must bill Medicaid for reimbursement. HB 393 calls for the Department of Health and Social Services to set up contracts with one or more health maintenance organizations (HMOs). Rather than paying directly

Medicaid eyed . . .

from page 1

to doctors and other providers, under the contract the state would just pay the HMO. Medicaid clients could use only HMO-approved doctors.

Rokeberg says choice restrictions should not be an overriding concern for Medicaid recipients, since the state is paying their medical bills. He also says managed-care will ultimately result in better health coverage for a broader number of Alaskans. Once the Medicaid managed-care system is put in place, it could be expanded, with inexpensive coverage made available to people not on Medicaid.

"If you're not in a group insurance plan, it's very difficult to buy insurance as an individual," Rokeberg says. He cites his own bad experience with health insurance companies as one of the reasons he became interested in the issue. When he and his wife turned 50 a few years ago, their insurance premiums jumped to $800 a month. "It was because of our age, and she had some medical problems that actually weren't serious," Rokeberg says.

'This is the only way I can see at this point where we can control the costs of Medicaid.'
- Norm Rokeberg

HB 393 requires the Department of Health and Social Services to submit a bill that incorporates a managed-care Medicaid plan at the beginning of next year's legislative session.

"Basically, my intention here is to start public discussion," Rokeberg says. "This is the only way I can see at this point where we can control the costs of Medicaid. This is a two-way street: to simultaneously make more benefits available, while keeping costs down."

Senior bill digest

HB 158 (Porter, R-Anchorage) Tort reform. Adds new limitations to the amount of non-economic damages plaintiffs may seek. Places limits on time in which plaintiffs may file malpractice suits. Places cap on punitive awards and requires half to be paid to the state. Requires jury awards be paid over a period of time, rather than in a lump sum. Currently in Senate Judiciary committee.

HB 185 (Ivan, D-Akiak) Senior and disabled veterans' property tax exemptions. Reduces mandatory senior property tax exemption from $150,000 to $75,000 of the assessed value of a senior's home. In Finance committee.

HB 198 (Elton, D-Juneau) Permanent Fund dividend eligibility and bereavement absences. Allows Alaskans absence from the state without affecting Permanent Fund dividend eligibility, if the absence is needed to care for a terminally ill family member or settle the estate of a deceased family member. Time outside on these duties will not count against the 180 day maximum absence rule. In State Affairs committee.

HB 308 (Parnell, R-Anchorage) Probate code amendments. Revises laws governing wills and handling of estate assets in absence of a will. Addresses children's and stepchildren's rights to parents' estates; clarifies who has access to life insurance benefits, and who can be legally considered a "surviving spouse." Currently in Judiciary committee.

HB 384 (Rokeberg, R-Anchorage) Payment requirements for Pioneers' Homes. Forbids the Department of Administration from evicting Pioneers' Homes residents who do not pay their full rent. Currently in State Affairs committee.

HB 393 (Rokeberg, R-Anchorage) Managed care for Medicaid recipients. Directs the Department of Health and Social Services to draft legislation creating a managed health care system for people on the Medicaid public assistance program. The Department must submit the bill to the legislature next session. Currently in Health, Education and Social Services committee.

SB 120 (Torgerson, R-Kasilof) State veterans' home facilities. Allows state veterans' homes programs to provide nursing home care or related medical services, and thereby quality for federal funding assistance. Currently in Finance committee.

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Finance

P.O.Box 113200
Juneau, AK 99811-3200
(907) 465-3795
FAX (907) 463-4885

MEMORANDUM

DATE: January 8, 1996

TO: Representative Norman Rokeberg
Attn: Mia Costello

FROM: Jetta Whittaker
Fiscal Analyst

SUBJECT: Medicaid Funding

You asked for a five or ten year summary of Medicaid funding broken out by major funding source. The attached spreadsheet offers a funding history starting with Actuals from FY92.

In order to get you some information as soon as possible, I started with data that was fairly readily available. To present a history for the years before FY92 Actuals will take a bit more effort, in that General Funds summaries were not routinely done and the numbers will have to be calculated. If you would like me to pursue this further, please don't hesitate to call.

Department of Health and Social Services
Medicaid Funding - Total Funds, General Funds, and Other Funds*

	FY92	FY93		FY94		FY95		FY96
	Actual	Auth	Actual	Auth	Actual	Auth	Actual	Enacted
Medicaid Facilities	99,548.1	126,863.4	105,609.0	112,951.3	131,803.1	125,387.3	131,465.5	145,270.4
General Funds	49,970.2	63,221.1	52,751.5	56,827.2	66,176.3	62,925.4	65,130.8	72,765.9
Other Funds	49,577.9	63,642.3	52,857.5	56,124.1	65,626.8	62,461.9	66,334.7	72,504.5
Medicaid Non-Facilities	86,446.6	90,893.2	100,766.7	116,460.5	114,343.9	133,892.6	121,220.5	135,333.4
General Funds	42,957.4	44,839.1	50,695.2	58,291.5	57,004.8	66,226.0	61,058.4	66,473.6
Other Funds	43,489.2	46,054.1	50,071.5	58,169.0	57,339.1	67,666.6	60,162.1	68,859.8
Indian Health Services	12,672.6	16,529.8	16,673.2	16,698.0	20,150.9	19,822.0	21,149.0	24,432.7
General Funds	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Funds	12,672.6	16,529.8	16,673.2	16,698.0	20,150.9	19,822.0	21,149.0	24,432.7
Medicaid State Programs	3,954.6	5,174.7	4,601.6	11,784.9	17,444.5	19,385.2	19,353.8	19,945.2
General Funds	0.0	186.6	0.0	1,663.3	3,649.5	2,081.7	2,187.8	3,523.2
Other Funds	3,954.6	4,988.1	4,601.6	10,121.6	13,795.0	17,303.5	17,166.0	16,422.0
Waivers Services				11,483.6	724.7	8,881.5	4,006.2	11,248.8
General Funds				5,741.9	362.4	2,364.8	886.6	2,256.3
Other Funds				5,741.7	362.3	6,516.7	3,119.6	8,992.5
TOTAL	202,621.9	239,461.1	227,650.5	269,378.3	284,467.1	307,368.6	297,195.0	336,230.5
General Funds	92,927.6	108,246.8	103,446.7	122,523.9	127,193.0	133,597.9	129,263.6	145,019.0
Other Funds	109,694.3	131,214.3	124,203.8	146,854.4	157,274.1	173,770.7	167,931.4	191,211.5

* "General Funds" includes General Fund, General Fund Match, General Fund/Program Receipts, General Fund Mental Health,and General Fund Program Receipts/Designated. "Other Funds" includes mainly Federal Funds, but may also include some InterAgency Receipts.

TANANA CHIEFS CONFERENCE, INC.
122 First Avenue, Suite 600
Fairbanks, Alaska 99701-4897
Phone 907/452-8251 • Fax 907/459-3850

Feb. 16, 1996

Rep. Con Bunde &
Rep. Cynthia Toohey
Co-chairs, HESS
House of Representatives
Mail Stop 3101
State Capitol
Juneau, AK 99801-1182

RE: HB 393

Dear Reps. Conde and Toohey,

I am writing on behalf of the Tanana Chiefs Conference, Inc. in general support of House Bill 393. We are aware that similar health delivery models have been implemented successfully in other states. Conceptually, we have no problem with recipients of medical assistance being served through a managed care model.

The bill does raise some questions about how Indian Health Service (IHS) beneficiaries will be treated under this bill. We note that Section 1(b) states *A system developed under (a) of this section MAY require that a recipient... participate.* Will IHS beneficiaries be exempt from participation under this clause, assuming they will continue to receive care at IHS funded facilities?

We would appreciate receiving any additional information to help us understand the full intent of HB 393, particularly as it applies to IHS beneficiaries. And, as always, the opportunity to comment is appreciated. Thank you.

Sincerely,

TANANA CHIEFS CONFERENCE, INC.

Eileen Kozevnikoff

Eileen Kozevnikoff
Director, Health Services

SUPPORT

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 21, 1996

Representative Con Bunde, Co-Chair
Representative Cynthia Toohey, Co-Chair
Health, Education & Social Services Comm.
Alaska House of Representatives
Juneau AK 99811-1182

Re: Support, HB 393
Medicaid Managed Care

Dear Co-Chair & Members House HESS:

Community hospitals and nursing homes support HB 393, directing the DHSS to develop a managed care or capitated health care system for Medicaid recipients.

Up until now, we have tended to dismiss "managed" care as not feasible in Alaska because of our small population and large (geographic) size, but the "no growth" Medicaid budget and/or potential reductions in Medicaid funding now mandates that we look at all options for the purchase and payment of health care.

Secondly, we understand HB 393 sponsor, Representative Rokeberg, is considering a substitute bill that would encourage the Department to work with provider groups in the development of a managed care option for the state, and that this plan would allow "pilot projects" to determine the feasibility of managed care before it is implemented statewide. These amendments strengthen HB 393.

Sincerely,

Harlan R. Knudson
President/CEO

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

for HB 393 file

State of Alaska
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Medical Assistance

MEDICAID PROGRAM CASE MANAGEMENT
RFP 95-0175

DELIVERABLE #3
REPORT OF OTHER STATES MANAGED CARE PROGRAMS

FEBRUARY 20, 1996

SUBMITTED BY:
FOX SYSTEMS INC.
HEALTH MANAGEMENT ASSOCIATES

SUBMITTED TO:
STATE OF ALASKA
DIVISION OF MEDICAL ASSISTANCE

FOX
4110 North Scottsdale Road, Suite 345
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Exhibit A

Medicaid Managed Care Status
State by State Commentary

Medicaid Managed Care Status
State by State Commentary

Name of State	Comments	Contact Person(s)
Alabama	• No Medicaid managed care plans currently contracted • Plan to offer HMO option beginning in Mobile area in 1995 and then expand to other areas • 1115 Waiver submitted to HCFA, 7/95 • Licensing is slow • Capitation appears as if it would be low • 1915 waiver for a coordinated system of pregnancy related services	Evelyn Terry, Outreach and Marketing Director 205-?42-5014 Debra Moore, Managed Care Division 205-242-5012
Alaska	• Plans for managed care currently underway • Currently have a contract for optical hardware	
Arizona	• Fully implemented prepaid capitated managed care plan statewide • Enrollment is mandatory for all eligible recipients except Native Americans • Three-year HMO contract bid let 10/1/94 (some areas have one HMO and others may have more than one HMO-It depends on the population and size of the area) • New RFP will probably be out in 2/97 • 1115 waiver pending to cover individuals up to 100% of poverty	John Black. Executive Consultant. Office of Managed Care 602-254-5522 ext. 7024

Name of State	Comments	Contact Person(s)
Arkansas	• Has a 1915(b) waiver • Operate a statewide PCCM • No HMO contracts • Nine county project for HMO option in the discussion stages • No commercial HMO covers the state now; BC/BS attempting to do so	Roy Jeffus 501-682-8329
California	• California aggressively seeking PHP contracts, just awarded dual choice (one county initiative, one private health plan) contracts in several counties • Very competitive • Statewide managed care program (combination of PCCM partially capitated and fully capitated programs) in place • Offers coordinated care programs for the elderly, ON LOK is an example • 1915 (b) waiver approved	Joseph Kelly/Kenneth J. Wagstaff, State of California-Health and Welfare Agency 916-654-8076 Jennifer Sugar Medi-Cal Managed Care Division 916-654-8070
Colorado	• Currently has a statewide PCCM plan: plan to phase out and use as "safety net" only in areas where no HMOs exist • Contracts with six HMOs, but HMOs do not cover the entire state • As HMOs become available in other service areas, will contract with them • 1915 (b) waiver approved	Kim Gordon 303-866-2220
Connecticut	• Received 14 responses to an RFP for fully and partially capitated plans to serve the Medicaid population beginning 7-1-95 • Phasing in statewide enrollment • May re-bid in two years • No PCCM program; no Medicaid contracted HMOs prior to the recent RFP • 1915 (b) waiver approved	James Gaito 203-424-5137

Name of State	Comments	Contact Person(s)
Delaware	• Received HCFA approval 5/95 for "The Diamond State Health Plan" (DSHP), which mandates enrollment in capitated managed care delivery systems • 1115 Waiver approved • Plan is effective 1/1/96	Kay Holmes, DSHP Coordinator 302-577-4900
District of Columbia	• Implemented DC Medicaid Managed Care program (combination of fee-for-service and capitated options) in 4/94 • Mandatory for AFDC and AFDC-related recipients • Medicaid Program is in financial difficulty • 1915 (b) waiver approved	Sue Brown, Commission of Health Care Finance 202-727-0735
Florida	• Florida has offered a managed care plan to Medicaid enrollees for 13 years • Plan to expand in March, 1996 • Has an HMO option, but it does not operate in all parts of the state; hopes to expand the areas where HMOs will serve Medicaid recipients • A QA study found all the capitated plans to be deficient so there is a temporary enrollment freeze for those plans • HMO Licensing both with the State and the Medicaid Agency is bogged down • Present enrollment is 1/3 MediPass (PCCM program) 1/3 HMO, and 1/3 regular fee-for-service • 1915 (b) waiver approved	Paige McGivern 904-487-3090

Name of State	Comments	Contact Person(s)
Georgia	• May begin to offer a Medicaid HMO option in the Atlanta area; currently reviewing HMO applications • Implemented their PCCM program, Georgia Better Health Care, in 10/1/93; operational in a few counties only • 1915 (b) waiver approved • Plans are underway to expand GBHC statewide	Patrick Williams 404-657-7793
Hawaii	• Hawaii Health Quest, which began 8-1-94, provides medical, dental, and mental health benefits through a capitated managed care delivery system to persons receiving AFDC, GA, and the State Health Insurance Program • Five private insurers have been given two-year contracts to provide benefits • One year lock-in • Will issue another RFP in late 1995 for the next two-year period • Open to accepting bids from mainland companies Current companies all Hawaii-based	Barbara Bianco, Public Information Officer 808-586-5454
Idaho	• PCCM model introduced in October, 1993 • No HMO option now • MMIS system will be reconfigured to meet managed care requirements. Work to be completed by 12/31/96. • After MMIS improved, will consider expanding the managed care option • Of the 44 counties, 7 are considered urban, 12 rural and 25 frontier (6 persons or less a square mile) • 1915 (b) waiver approved	Jan Cheever, Supervisor. of Healthy Connections 208-334-5804 or Robin Schmidt, Healthy Connections Representative 208-334-5804

Name of State	Comments	Contact Person(s)
Illinois	• 1115 waiver request pending with HCFA for MediPlan Plus, which will contract with HMOs statewide to care for the MediPlan Plus eligibles; a PCCM program is also operational • Has contracted with HMOs in portions of the state for 20 years • Hope to release an RFP soon for HMOs to bid • Medicaid eligibles concentrated in Chicago, Peoria, and East St. Louis	Dawn Clarom 217-524-7478 Ed Hartman Bureau of Managed Care 217-524-7478
Indiana	• Has a PCCM program and is introducing risk-based capitated managed care option • During the summer of 1994, implemented a mandatory managed care program called Hoosier-Healthwise • Phasing in managed care regionally over three-year period, depending on access and participation • Use an enrollment broker to enroll recipients • 1915 (b) waiver approved	Wendy Bokota 317-233-0237
Iowa	• Currently offers a mandatory PCCM or HMO option to Medicaid recipients • The HMO option is not available statewide • Iowa wants to contract with HMOs to serve areas currently not offering an HMO option • 1915 (b) waiver approved	Mary Roberts, Dept. of Human Services 515-281-8747

Name of State	Comments	Contact Person(s)
Kansas	• Has a statewide PCCM program • 1115 waiver pending; project (Community Care) would implement a managed cooperation demonstration project in four predominantly rural counties and would assess the success of a non-competitive managed care model in rural areas • In December, 1995, plans to offer an HMO option in Kansas City area and then will expand to different areas of the state • In December, 1996, proposes to sole-source contract with a prepaid health plan for the Wichita area (The plan is made up of hospitals and providers in Wichita)	Brenda Jackson 913-296-3981
Kentucky	• 1115 Waiver approved by HCFA but state legislature has not allowed implementation • Medicaid agency wants to implement a mandatory HMO program for Medicaid eligibles • Currently has a PCCM program statewide • 1915 (b) waiver approved	Larry McCarthy 502-564-8196
Louisiana	• State has amended 1115 waiver request (original waiver was disapproved by HCFA in 6/95); still under HCFA consideration • All Medicaid enrollees would be required to join competing HMOs under contract with the state • Currently has a PCCM program	Carolyn Maggio, Director 504-342-2964 Bonnie Butler, Analyst Health Development 504-342-6068

Name of State	Comments	Contact Person(s)
Maine	• HMO RFP was released in April 1995 • Intends to implement a mandatory managed care option • Established PCCM program; will be phased out except in three rural counties • 1915 (b) waiver approved	Deborah Curtis, Director, Division of Managed Care or Lauren Rice 207-287-3835
Maryland	• PCCM program (MAC Program) implemented 12/91 • HMO option available since 1975 • Enrollment in HMOs is voluntary • Capitation paid at 95.5% of fee-for-service, including a consideration for administration • 1915 (b) waiver approved	Dawn L. Grosshandler, Chief 410-225-5444
Massachusetts	• HCFA 1115 waiver, MassHealth, approved 4/95; awaiting approval from state legislature • Statewide HMO and PCCM option • Enrollment mandatory • Health benefit managers enroll recipients (currently have a bias toward the PCCM program)	Michael Bailit, Asst. Commissioner 617-348-5510
Michigan	• Has implemented a statewide mandatory managed care plan • Has a statewide PCCM plan, the Physician Sponsor Plan • The HMO option and the partially capitated plan, the Clinic Plan, are primarily available in central and southern MI, although expanding to other areas • Over 90% of non-institutionalized AFDC and SSI clients enrolled in managed care • 1915(b) waiver approved	Mark Verleger 517-335-5501

Name of State	Comments	Contact Person(s)
Minnesota	• 1115 waiver, Prepaid Medical Assistance Project Plus (PMAP), approved 4/95 • Will expand eligibility and place persons in integrated service networks • Especially interested in expansion in rural areas • HMO option currently available in some regions	Kathleen Schuler, Acting Director, Managed Care Division 612-297-4668
Mississippi	• Has a PCCM option; considering HMO option, but nothing has been developed • Currently has a 1915(b) waiver • HMO licensing regulations currently being changed by the legislature	Judith Michael 601-359-6133
Missouri	• Has submitted both a 1915 (b) and an 1115 waiver request; approval is still pending • Has operated mandatory choice health plan options program in Kansas City since 1984 • Seeking legislative support for managed care expansion • Plan a three to five year process to fully implement managed care on a regional basis • HMOs will bid based on a capitation range published in the RFP	Gary Bailey 314-751-6922 Linda Vaughn, Management Analysis Specialist; Managed Care Division 314-751-7820
Montana	• Expanding the PCCM option and introducing an HMO option • Many counties are rural and frontier • Encouraging HMO development/expansion in areas not covered currently • 1915 (b) waiver approved	Sharon Donavan 406-444-4148

Name of State	Comments	Contact Person(s)
Nebraska	• Let two competitively bid contacts (each covering one half of the state) with two HMOs who will cover the state in Spring, 1995 • Will not re-bid for two years • Implementing a statewide PCCM program using a contracted network manager	Bob Seiffert, Medical Services Division 402-471-9718
Nevada	• PCCM program since 1983 • Medicaid has contracted to provide care and service under a pre-paid health plan since May, 1988 • Current contractors are University of Nevada School of Medicine, NevadaCare, Inc., and Community Health Centers of Southern Nevada (an FQHC)	Joanne Grundmen, Program Specialist 702-687-4768
New Hampshire	• Currently contracts with HMOs • Voluntary program at this time • State is looking at pilot initiatives to help in the redesign of its healthcare system • 1115 waiver pending	Diane M. Kemp, Program Specialist 603-271-4365
New Jersey	• 1915 (b) waiver pending at HCFA • Plans to implement an HMO-only mandatory enrollment program • Currently contracts with HMOs but not in every area of the state • Have 400,000 additional recipients to enroll in a plan • Use health benefit managers to enroll recipients	Daniel Walsky, Director of Medicaid Managed Care 609-588-2705

Name of State	Comments	Contact Person(s)
New Mexico	• Primary Care Network (PCN), a PCCM program, is currently operational statewide • Plans to offer an HMO option in the urban areas in 1996 • Currently redesigning MMIS to support full managed care functionality • 1915 (b) waiver approved	Paul Benson, Chief Office of Managed Care 505-827-3122
New York	• Currently has capitated, partially capitated and PCCM programs • Plans to implement a mandatory HMO program throughout the state within the next two years • New York City plans to enroll all Medicaid eligibles living in NYC within one year, HCFA disallowed the plan • The governor appointed a director of managed care in the Dept. of Public Health who will coordinate all efforts outside of NYC • NYC will administer its own program • 1915 (b) waiver approved	Jim Wray Director, Office of Managed Care 518-473-5600
North Carolina	• Carolina Access, a PCCM program is in 38 of 100 counties (covers 50% of eligible population); currently re-grouping; plans to expand in early 1996 • Has an HMO contract with Kaiser Permanente • May introduce an HMO option in the Charlotte area • 1915 (b) waiver pending	Nancy O'Dowd or Joe Robbins, Division of Medical Assistance 919-715-5417

Name of State	Comments	Contact Person(s)
North Dakota	• PCCM program for AFDC eligibles; preparing waiver renewal for statewide program • May implement an HMO option in the eastern part of the state • Has done preliminary rate setting only • Only two small regional HMOs in the state now • 1915 (b) waiver approved	Darlene LeNoue, Administrator, Medical Services Division 701-328-4577
Ohio	• Plans to implement OhioCare; the 1115 waiver (approving OhioCare and expanding eligibility) was approved 1/95. However, State has decided to delay expansion pending Congress' discussion on budgetary matters • Current recipients will be moved into managed care plans; mental health and drug addiction benefits will be coordinated • Will rely heavily on HMO contracts • Currently contracts with HMOs to provide services for the Medicaid population • RFP will be issued • 1915 (b) waiver pending	Cynthia Burnell 614-466-4693
Oklahoma	• Wants to begin "Sooner Care"; HCFA approval of 1115 waiver is pending • Project would be a five-year statewide managed care program using both fully and partially capitated delivery systems. Emphasis will be to address access problems in rural areas • Issued an RFP to HMOs that was due back 3/24/95; will reopen HMO bidding annually	Leigh Brown, J.D. M.P.H., Deputy Administrator for Health Policy 405-530-3439

Name of State	Comments	Contact Person(s)
Oregon	• Began the Oregon Health Plan 1115 demonstration on 3/19/93 • Uses managed care models including fully capitated, partially capitated, and PCCM programs • Currently contracts with many HMOs • 90,000 eligibles enrolled in HMOs as of 6/1/94 • Considering proposal for $5 co-payment for doctor visits for those newly eligible • 1915 (b) waiver approved	Hersh Crawford, Director 503-945-5767 D'Anne Gilmore, Health Plan Unit 503-945-9827
Pennsylvania	• State has a PCCM program (HealthPASS) • Has some HMO contracts and is interested in contracting with additional HMOs in other areas of the state • Planning statewide expansion over next three year; expansions will begin 7/96 in Philadelphia area • Uses a competitively bid approach in parts of Philadelphia for an HIO to manage PCCM program; huge profits were reaped in first contract period • 1902 (b) waiver approved	Frank Lentz, Director, Bureau of Special Medical Assistance Programs Michael Jacobs 717-772-6198

Rhode Island	• 1115 waiver approved in Fall, 1993 for Rite Care which will:
	  • expand eligibility under Medicaid
	  • implement a fully capitated managed care delivery system
	• Recipients enroll in one of 5 existing HMOs
		Ron Ek
		401-464-3113

Name of State	Comments	Contact Person(s)
South Carolina	• Originally wanted to implement a statewide capitated managed care plan but have scaled that back and may not offer an HMO option at all, or if it does, will be voluntary • Currently has a PCCM program • 1902 (b) approved	Debbie Francis, Chief 803-253-6119
South Dakota	• 7/1/93 began a PCCM program • Currently awaiting approval of waiver renewal • No HMO contracts • 1902 (b) wavier approved	Donna Keeler, Dept. of Social Services 605-773-3495
Tennessee	• TennCare, 1115 waiver approved Fall 1993, replaced the Medicaid program and extended eligibility to 1 million additional recipients • Services are offered through five PPOs and seven HMOs • Market-based pricing	Manuel Martins, Ass't. Commissioner 615-741-0213
Texas	• Legislature currently debating the future of Medicaid • Many want to offer or mandate HMO coverage in most parts of the state • Has both an HMO and a PCCM option in different areas of the state • 1915 (b) waiver approved	Stacey Hull, Program Specialist 512-794-6852
Utah	• Choice of Health Care Delivery (CHCD), a 1915(b) waiver program, is mandatory in urban areas only; recipients choose between HMO and primary care physician • HMO option available in urban areas only • 1115 Waiver pending to expand eligibility to 100% of poverty	Ed Furia or Barbara Christensen, Div. of Health Care Financing, Bureau of Managed Health Care 801-538-6505 or 538-6456

Name of State	Comments	Contact Person(s)
Vermont	• 1115 waiver approved, The Vermont Health Access Plan, proposes to implement mandatory HMO enrollment. It will also expand coverage to 150% of poverty; HCFA approved the waiver 7/95 • State legislature has approved plan to expand coverage, effective 1/96; funding will be gained through cigarette tax revenues	Paul Willis 802-828-2900
Virginia	• There are three managed care programs: Medallion I, a PCCM, started in 1992; Options, the state's voluntary HMO; and Medallion II, the state's mandatory HMO. Medallion II is scheduled to go into effect 1/96 • Will begin to offer HMO option in the Norfolk area 1/96 and will implement in other urban areas every six months (Northern VA. Richmond, Roanoke) • PCCM program was expanded to cover elderly, blind and disabled recipients in July, 1995 • 1902 (b) waiver approved •	Thomas McGraw 804-371-6400
Washington	• Has a PCCM program • Mandatory enrollment in managed care is required for AFDC and AFDC-related • 1902 (b) waiver approved •	Joan Bentz, Acting Director. Office of Managed Care 206-586-2583
West Virginia	• Has a statewide PCCM program • In the planning stages and wants tc offer an HMO option, probably one year away • 1902 (b) waiver approved	Sharon Carte 304-926-1717

Name of State	Comments	Contact Person(s)
Wisconsin	• Has both HMO and PCCM programs • HMOs are present in only 5 of the 72 counties; HMO enrollment is mandatory in these counties for AFDC recipients • PCCM program is available in 7 counties • Will release an RFP for statewide expansion in December 1995 • Plan to implement managed care in stages • 1902 (b) waiver approved	Ruth Belshaw, Managed Care Unit Supervisor 608-266-1935 Mary Durkin 608-267-7927
Wyoming	• No managed care programs in operation • Hoping to offer both a PCCM and HMO option	Kenneth C. Kamis, Administrator, Division of Health Care Financing 307-777-7531

Exhibit B
Glossary of Abbreviations
Used in the Text

Glossary of Abbreviations Used in the Text

Abbreviation	Meaning
1115 Waiver	A research and demonstration waiver granted by the Health Care Financing Administration
1915 (b) Waiver	A waiver granted by the Health Care Financing Administration aka Freedom of Choice Waiver
AFDC	Aid to Families with Dependent Children
BC/BS	Blue Cross Blue Shield
Carolina Access	North Carolina's primary care case management program
Case Managed Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as enhanced fee-for-service or managed fee-for-service.
Community Health Aide	A person living in a remote Alaskan village who has been appointed to oversee health care activities and provide services within a specified framework.
DMA	Division of Medical Assistance
DSHP	Diamond State Health Plan, Delaware's 1115 waiver program

Enhanced Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as case managed fee-for-service or managed fee-for-service.
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FFS or ffs	Fee-for-Service
FQHC	Federally Qualified Health Center
GA	General Assistance -- state-only funded medical program
GBHC	Georgia Better Health Care; Georgia's PCCM program
HCFA	Health Care Financing Administration
Healthy Connections	Idaho's primary care case management plan
HEDIS	National Committee for Quality Assurance, Health Plan Employer Data and Information Set
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
IHS	Indian Health Services
KenPac	Kentucky's primary care case management plan
Lock-In	Refers to a period of time during which a health plan enrollee may not disenroll from a health plan except for good

	cause. May also refer to a recipient monitoring program developed to monitor access to care for high utilizing recipients.
Managed Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as enhanced fee-for-service or case managed fee-for-service.
MCO	Managed Care Organization
MediPass	Florida and Iowa's primary care case management plan
MediPlan Plus	Illinois' 1115 waiver program
Mid-Level Providers	Nurse Practitioners, Nurse Midwives and Physician Assistants are often referred to as mid-level providers
MMIS	Medicaid Management Information System
Partial Capitation	Programs are structured to reimburse managed care organizations for a specific set of contracted services at a per member per month capitation rate. Members must seek care covered by the MCO within the MCO's panel of providers. Services outside of the partially capitated contract may be reimbursed through a contract or fee-for-service basis.
Passport to Health	Montana's primary care case management
PCCM	Primary Care Case Management

PCCP	Colorado's Primary Care Physician Program (a PCCM program)
PCN	Primary Care Network, New Mexico's primary care case management
PCP	Primary Care Physician
pmpm	Per Member Per Month
PPP	Primary Provider Program, Wisconsin's primary care case management program
PSP	Physician Sponsor Plan, Michigan's primary care case management program
QA	Quality Assurance
RFP	Request for Proposals
RHC	Rural Health Center
Rite Care	Rhode Island's 1115 waiver program
RMP	Recipient Monitoring Program, also known as "lock-in"
SSI	Supplemental Security Income
SURS	Surveillance, Utilization and Review System
Waiver	A mechanism by which HCFA authorizes a state Medicaid agency to "waive" Title XIX regulations. There are two waiver authorities that HCFA can do -- 1115 and 1915(b).